U.S. CONGRESSMAN JOHN CONYERS JR.

DISCUSSION ON AMERICAN HEALTH CARE

P R O C E E D I N G S

REP. CONYERS: Greetings. I'm delighted to have my colleague, Representative Donna Christensen from the Virgin Islands, a medical doctor herself, join with me and Dr. Edith Rasell, who's with the Economic Policy Institute, a senior fellow and an activist, and Dr. Quentin Young, the national coordinator for a national health plan.

DR. YOUNG: Exactly.

REP. CONYERS: From Chicago and other places. We're delighted that all of us could be here at the same time and place to begin to look into the questions of health care and what the current problems are in our health care delivery system.

Now, the other questions I'm hoping we can get to quickly are, what are some of the health care proposals that have been introduced, and then what do we think our health care system would best go in -- in

what direction it would go in.

So let's start off with a discussion about the problems with access, affordability, prescription drugs, and other concepts.

I start with the statistic that's the most glaring: Some 44 million that don't have any health insurance at all. And then it gets a little bit better from there.

But that's an appalling statistic that seems to be growing; is it not?

DR. YOUNG: Absolutely. Well, they are full of it, because it's burdening everybody at this table. Every year, it goes up. There was a slight dip last year.

But since '93, when Mr. Clinton's proposal went down in flames, it's gone up about a million a year -- 44 million people, more or less. And I think it's important, given the current economic disturbances, that that number will go up, not another million, but maybe 10 million overnight.

So access in terms of health insurance is a terrible problem. Cost -- it's a ripoff. The American people are paying more than any country in the world for their services, limited as they are to the uninsured and others. To be precise, it's $1.3 trillion, $1300 billion.

REP. CONYERS: Annually?

DR. YOUNG: Annually, this year. It will be more next year. That ciphers out to $4,200 for every person in the country, approximately twice what the next countries are spending. So we're being ripped off. If it was a great system, I think we'd say it's worth it. It's a bad system. Quality, cost, and access are all in trouble.

REP. CONYERS: Congresswoman?

REP. CHRISTENSEN: Yes. I just wanted to add that a large portion of the uninsured are also minorities, although they span the whole population. Because 14 percent of non-Hispanic whites are

uninsured. But 37 percent or so of Hispanics, 25 percent of African-Americans, and about 20 percent Asian-Americans and Pacific Islanders are not insured.

DR. YOUNG: People of color are disproportionately larger among the people without any health insurance.

REP. CHRISTENSEN: Absolutely. And it is reflected in our health status.

DR. YOUNG: Exactly. Yes.

DR. RASELL: And one other point about the uninsured is that 10 million are kids. And most of the uninsured people work. So -- I think people forget this.

DR. YOUNG: Yes.

DR. RASELL: We have this image maybe that there are all these deadbeats out there or something. And that's absolutely not true. Almost across the board, these are people who live in families where people work.

So the problem is that employers

who have the option of providing health insurance are not -- and many of them, of course, do -- but many don't. And so it's usually folks with the lower-wage jobs, the lower salaries, who also don't get health insurance from their employer and don't have the money to go out and buy it themself who end up uninsured.

DR. YOUNG: You know, John, you must add to the uninsured the underinsured.

DR. RASELL: That's true.

DR. YOUNG: People who with any illness of any dimension are immediately impoverished. And that's just the point where I'd like to note that the biggest single cause of personal bankruptcy in this country is unpaid medical bills.

So the system, far from being healing and helping, is making huge economic problems for our people. And it doesn't have to be that way. This is the one social problem, I argue, that has the resources in

place. Whether you're talking actual dollars, as I tried to do, or capital plant, numbers of doctors, we're way ahead. But we can't seem to put it together.

REP. CONYERS: No. We're talking now about affordability. Let's take a look now at the new problem, affording prescription drugs, being able to do what your doctor tells you to do, which 30 years ago wasn't as big a problem as it is now, because we've made so many advances.

And so now we're finding that that's a new problem. And then we have this problem of gaps in the Medicaid program itself. Could we talk about those? Where do those lead us, Donna?

REP. CHRISTENSEN: Well, all of us have been in practice at some time or another as physicians. And the difficulty in trying to make sure that your patient would have enough medication to get them through the month, given all of the other needs, and many

of them on fixed incomes, especially the elderly, it is just impossible.

And prescription costs are going up, rather than going down. And this is something that we have to address.

DR. YOUNG: It should be emphasized that you're right in saying we've got new drugs and they're costly. But it's also fair to note that the drug industry in this country is the most profitable major industry. And I think we've all been exposed to the information that you go across the border, to Canada or to Mexico, and all of a sudden, the same drug, the same company, the same quality, is 60 percent less. So another ripoff.

There's a lot of proposals out there -- and I know you want to talk about proposals later, but let me just say this -- to pay for those drugs. We have Medicare, which is a wonderful program. Some have argued it's the most popular social program

we have, maybe exceeded by Social Security itself. But when you have a person on a fixed pension and 3- or $400 of prescriptions a month, there's no go.

So we should provide universal coverage for those prescriptions, get the price down, and make that part of the Medicare package. Because Medicare means very little if you can get the diagnosis, and can't take the treatment.

DR. RASELL: And prescription drugs are a large piece of the problem for people that have insurance, but can't get the care they need. And I also wanted to just make sure that people realize that that's not the only problem. Many of the people that have insurance don't have coverage for the things that they need. And the numbers here -- we think that probably just about as many people who are uninsured, almost that many people are underinsured.

Let me rephrase that.

REP. CONYERS: Yes.

DR. RASELL: If we have 40-some million people who are uninsured, there's probably another 30-some million who are underinsured, meaning that they have insurance, but for important things that they need, they're not covered. And the one we always think of is prescription drugs. But it could also be things like physical therapy or certain services. We know a lot of people are not covered for dental care or eyeglasses.

REP. CONYERS: Home care.

DR. RASELL: Home care. There's a lot of gaps. Mental health care is a very important one. And then the whole problem with people that maybe get offered insurance on the job, but it may require them to pay a couple of hundred dollars a month, or 3- or $400 a month, just in order to get the insurance that their employer offers. And some people, we know, can't afford it. And

so they're forced to not take the insurance and not be insured, because they can't afford the large amount of money it would cost them every month just to be insured.

So there's a zillion problems with the system.

REP. CONYERS: Donna, did you want to say something?

REP. CHRISTENSEN: I just wanted to say something about Medicaid, because you mentioned Medicaid as well.

REP. CONYERS: Yes.

REP. CHRISTENSEN: In addition to being able to have Medicaid as one of the covereds, you have to look at how much it does cover.

And we've seen, through some of the studies that have been done, that even patients who have Medicaid do not receive the same level of services as the insured. In one study that was looking at HIV and AIDS, they received no more treatment, either it

was HIV and AIDS -- the cocktail, or the prophylaxis -- than those who were uninsured.

And in the Territories, we have a cap. So there's a large gap between who's at the poverty level and who is able to be eligible for Medicaid. So there are a lot of issues around Medicaid as well.

REP. CONYERS: Would you just restate that one more time, so that --

REP. CHRISTENSEN: About the study about AIDS?

REP. CONYERS: Yes. About the differences, the disparities that you mentioned.

REP. CHRISTENSEN: Well, there was a study that was called the HIV cost utilization study. I think it was done by Rand. And they looked at -- they were trying to determine how many of the HIV-positive persons in the United States were actually in care.

And one of the findings -- they

looked at people who were insured, people who were uninsured, and people who were on Medicaid. And they looked at several parameters. They looked at doctor visits. Now, for Medicaid patients and insured patients, the doctor visits were about the same. For uninsured, they were zero to maybe one.

But when they looked at treatment, those patients on Medicaid did not receive the same treatment as the insured. They received none.

REP. CONYERS: Which is the purpose you go to the doctor for.

REP. CHRISTENSEN: They went to the doctor. They received no treatment.

REP. CONYERS: So visits alone don't get it?

DR. YOUNG: No.

REP. CONYERS: I mean, it's what happens --

REP. CHRISTENSEN: So there's

another level that you have to look at, even when someone has Medicaid as their primary insurance.

DR. YOUNG: I think she's making a terribly important point as we get to the examination of what the problem is.

We have a patch quilt of ways of taking care of our people. We're up to 280 million, I think the last census tells us. We've already identified a fourth who are out of the loop based on no or underinsurance, in a sense.

But then, there are ways we go at it. Yes, there's employee-based payments, but they vary a lot. And I want to underscore what Edie just told us, because the trend is toward offloading the cost on the worker. In other words --

REP. CONYERS: How do you do that?

DR. YOUNG: You just say, you've got to pay $200 a month if you want the insurance. That's called a wage cut, in

normal circumstances. It really is, because that's in lieu of wages, and all of a sudden, they want more of your money. So it impoverishes the worker along the way.

And then we have Medicaid mentioned. And I really think that's the heart of the matter. When you have a special system for the poor, it's vulnerable, and you get the discrepancies.

What am I getting at? You can tell what I'm going for. We need one system with everybody in, nobody out, a card that says -- like Medicare, really, which, with all the criticism, is fair to all people who reach that golden age of 65.

So we have to think of -- I always put it this way -- joining the rest of the human race, which has, over the past century, one by one, came to the obvious conclusion that health care is too important to leave to the vagaries of the market; that people, for the good of the nation, must be attended.

REP. CONYERS: Well, let me look at it like this. We have now a managed care system. And I was talking about this, in which you drive down the streets of my city, and you see all of these billboards: Come to this hospital, our emergency rooms are not waiting rooms, we'll get you in. And nobody waits more than 45 minutes. Another billboard: This hospital specializes in childbirth. I mean, if you're having a baby, this is the great place to go. These are all billboards I can remember. And then you have another one that advertises this particular HMO -- this plan is superior to all others. And then you have all others also advertising their plan.

And so, what you get -- and then two more billboards, and then I'll be through. One billboard -- I just saw it. The City -- from the Department of Health in Detroit, it says, if you're pregnant and uninsured, call this number, which -- and

they have a young person, apparently expecting. And wow, everybody says, that's great, too.

So what you have is this sea of advertising of HMOs, of managed care plans, of special systems. Then our county came in. A new billboard. The county system. This is the best system of all; it's brand new. Please join the --

And so I can see a family with about this many brochures, trying to figure out, well, we do need care for pregnancy, we do want to bring up -- we want a place where you can go into the emergency quickly. You do want something for pediatric. And you do want low cost, and you do want friendly service. And so I'm trying to lead up to two considerations, and to others that you have.

Why do we have so many overlapping plans? And how in heaven's name can an ordinarily concerned family plow through these sea of medical decisions?

Please start us off, Edie.

DR. RASELL: Well, I don't think an ordinary family can. I know I couldn't, you know, read different policies and decide what's best for me. And I think you've really hit upon one of the main problems with our current system. We have all these various HMOs that people are supposed to choose among. And that is, many of these are for-profit companies. They're traded on Wall Street. They have to be responsive and work for the interests of their stockholders, which is not how medicine used to be, as many of us remember.

And we're wasting money with all this advertising. We're wasting money when these companies are out there competing and trying to convince us to join them, and putting out these flashy brochures. I mean, what happened to standard practice of medicine, where doctors, and hospitals, and everybody was in it, you know, to do the

right thing by the patient? We've lost that.

REP. CHRISTENSEN: And that money comes out of patient care.

DR. RASELL: That's right.

REP. CHRISTENSEN: The patient care that's denied for specialty visits, for emergency room visits, and different diagnostic tests. It goes to advertising.

DR. YOUNG: Congresswoman, I called this our failed experiment in market medicine. Notice the word "failed." After the implosion of the Clinton plan, nothing happened. Congress didn't -- as it usually does -- have a substitute, a modification.

REP. CONYERS: We were shell-shocked.

DR. YOUNG: That's right. And there's nothing. Into that void, we were told, the market will do it. Now, what I'm about to say is heresy these days. The market is almost the religion of many of our political leaders, and to criticize it is

heresy.

Well, I'm criticizing it in medicine. And I don't say all markets are bad. I can think of many that are very good, that have got us more efficiency, lower costs, better product.

But not in health care, and why? I think Edie was hinting toward it. In health care, the way you make money is denial of care. You have to avoid sick people. And we know who they are, and we know how to avoid them. Or, if you get them, darn it, you have to do everything you can to put barriers to their getting care.

That's what the hue and cry that I have to believe you and every one of your colleagues in Congress are getting about denial of care and inability to get the attention. And this is a human experiment. It's not unlike Tuskegee, which has come to be a shame to the national experience.

REP. CONYERS: The Tuskegee

syphilis tests?

DR. YOUNG: Exactly, where doctors knew that the patients were being harmed and not helped, and they went on. I argue that that's exactly what this marketplace experiment -- people are being hurt, and we read daily in all the newspapers, are more than hurt. Death.

REP. CHRISTENSEN: One of the things that we went through late last year was the Medicare givebacks. And I can remember having to argue that HMOs were to get a large part of those Medicare givebacks. Not so much to home health care. Home health care hospitals and providers, other providers, got some. But a huge chunk went to HMOs.

And we argued then that they don't take that care of that many Medicare patients, and that they had been dropping them. And then it passed. They still got a huge chunk of that money. And what did they

do? Drop more Medicare patients from their rolls.

REP. CONYERS: Now, let me shift this discussion of problems to discrete groups within the health care industry -- namely, hospitals and doctors. Because what I'm beginning to learn -- and tell me if this is accurate or not -- is that some of the city hospitals are now becoming the repository for everybody that dcesn't have insurance. And some of the hospitals located out of the cities are becoming more exclusive for those who have insurance and coverage.

And so this is putting a huge weight on these local hospitals, who are not getting paid. Many of them are having problems with their Medicaid reimbursement from the states. There are great questions about whether they can even get their costs paid, much less make anything to stay in business.

And so we have this huge struggle

going on in which some nonprofit hospitals are now going profit. And there's a great story there.

What do you think the implications are there, and do you see that happening the way I've just described it?

DR. RASELL: I think you have hit it on the head. And even more than -- to take it one step further, many of these public hospitals have gone out of business, have shut their doors for financial reasons.

They were not getting reimbursed for the patients that they saw. They saw a lot of the uninsured. And they just couldn't make it.

REP. CONYERS: Let me just move to her for a while. A lot of minority hospitals, African-American hospitals, have gone under. You know, the numbers have gone down, haven't they?

REP. CHRISTENSEN: Yes. And one of the bills that we introduced -- I know you're

going to talk about some bills later on -- was HR 1860, which was the Medically Underserved Access to Care Act, which would require Medicare and group insurances -- HMOs and group insurances, which provided care to Medicare and Medicaid patients, require that they provide services in neighborhoods where there were higher-risk people, in the medically underserved neighborhcods, and that they also seek out providers frcm those areas and include them in their provider pool, as well as provide some grounds to community organizations to help people maneuver through that system.

As you asked before, how can you possibly figure out, with all of these competing advertisers, who to go to? But I just wanted to add that in.

DR. YOUNG: I wanted to address your earlier question about America's doctors. We said very little, but very important things about the hospitals.

It's worth knowing, because I don't think the public has a deep sense of our wonderful medical profession, which enjoyed top billing, highest prestige, a lot of respect. The last decade or two has seen a sharp decline in -- I call it the physicians getting depressed, because their autonomy has been usurped by these HMOs, who tell them through surrogates who have no training whether they can keep a patient in the hospital, or they may order this treatment. And there's no question that *en masse*, American doctors are in a state of confusion and dissatisfaction.

And that's not good. I know there are critics. I'm a practicing doctor, and I don't think our profession has acted absolutely perfectly every year of their existence. On the other hand, they're the only doctors they have. Their interest in the patients under normal conditions are the same; namely, they prosper when their

patients do well. That's been turned around with the HMO arrangement.

So I believe part of the issue and part of the solution is winning America's doctors to a different position. Historically, the leaders of medicine, notably the AMA, have been opposed to universal coverage; they have said that this is government medicine and tax-based, and arguments that I feel were hurtful, because they're very influential.

I think more and more doctors -- certainly our group, Physicians for a National Health Plan -- are harvesting the numbers of doctors who say, we've got to get away from what we've got if we're going to have a decent health system.

REP. CONYERS: I think you're right, because the American Medical Association invited me to their convention in Miami last year. And it wasn't because they were ready to sign on to all of our bills.

But it did mean that they're taking another hard look at the wall and the hard place -- the rock -- that they're caught up in.

And we supported them getting an added trust exemption -- you getting an added trust exemption -- so that you could meet and talk about the circumstances and conditions of your practice and the hospitals that you serve in, rather than being slapped with an antitrust suit because you don't have this exemption.

And they have begun to realize that they are now being oppressed by a system that doesn't allow them to maintain the doctor-patient relationship that you've always enjoyed.

But more than that, you're also being harassed by the insurance companies and the managed care criteria that can determine whether you even stay in practice. Because their rules are so strict that they don't allow you to talk to other people -- and

sometimes not Congressmen, even.

And they find that what they imagined when they went into medicine and medical school really, in practice, doesn't exist. And so, there's a big problem there.

Now, connected with that is the plight of the nursing profession.

DR. YOUNG: More sericus.

REP. CONYERS: Which is really critical, because now I'm being explained that it also has something to do with how many beds you can occupy in a hospital, because the nurses -- who have been traditionally underpaid and expected to be totally dedicated and who are also receiving more and more professional obligations -- they're assuming more and more parts of the practice that they didn't have before. But they're not getting compensated. They can get jobs in any other field.

And so it's become very hard for us to bring in the nurses, men and women, who

want to work in this profession, because we're not willing to compensate them for the high-level quality that is required for them to maintain their profession.

DR. YOUNG: That's very important. There's been a -- this nursing profession, I've said for the longest time, because it's absolutely true, what we do is called health care. The caring in the profession comes in large part from the nurses, who have, as you said in passing, been undervalued historically.

REP. CONYERS: Yes.

DR. YOUNG: Currently, they're being -- you mentioned some of the things. Let me mention another. They are hiring people with much lesser skills to replace nursing duties that take much greater skills.

And who is the ultimate victim? The patient.

So in a variety of ways, we've undermined the pillars of our health system,

even as we squandered more money than anybody else in the world.

REP. CONYERS: Edith?

DR. RASELL: You've mentioned the problems for the public hospitals. But another thing we need to talk about is what's happened with the community hospitals and the hospitals -- and the majority of the hospitals, which for the most part used to be nonprofit; they did not operate to make money; they were very concerned about serving the community.

But in recent years, many of those hospitals have joined for-profit chains or been bought out by for-profit companies. And so now they're concerned with making a profit.

And part of that process is that they need to do more with us, right? They've got to get more work out of their employees, cut corners, or cut costs in various ways. And one way we're seeing that is they're

trying to get by with fewer nurses -- and with nurses: Fewer RNs and more LPNs. Fewer LPNs. More nursing aides.

And so responsibilities get shifted; workloads increase. And a lot of the nurses are very upset about it, and feel that quality has suffered, which I think is something we all should be concerned about.

REP. CHRISTENSEN: I don't have anything to add to that, but --

REP. CONYERS: That really caps it up.

Now, let me move toward closure with this question. How do we go about getting more and more of our citizenry -- since this subject affects everybody of every age and status in life and location -- it seems to me that in a democratic society, you have to build up a head of steam to get anything done legislatively. That's the whole history of the process. And of course, there's a lot of things that need to be done

in other areas, too. You know, we're not talking about education, job training, the criminal justice system, and numerous other problems.

So we're hoping that people will listen to this discussion and, where they want, add their own concerns, make their own points.

How do you think we can move forward in this kind of educating, motivating mode that we're really in, which is a precondition to us getting it even then?

REP. CHRISTENSEN: Well, you know, unlike the AMA, the NMA, the National Medical Association, has now been --

REP. CONYERS: For African-American doctors?

REP. CHRISTENSEN: It's long been on the record in favor of a single-payer universal coverage health -- universal health insurance. But our health brain trusts here, which has many partners --

REP. CONYERS: Which you head?

REP. CHRISTENSEN: Which I head, and which has many partners around the country -- are going to make this an issue for --

REP. CONYERS: Very good.

REP. CHRISTENSEN: Beginning with this year. And we have a spring brain trust every year, and we --

REP. CONYERS: In Washington?

REP. CHRISTENSEN: Yes. It'll get back to you. We've been talking to your office about doing a rally on the Capitol steps to call attention.

REP. CONYERS: Sure.

REP. CHRISTENSEN: We need to, you know, elevate the awareness of people, call attention to this issue. It will be easy to have people make the connection to why they're not getting the health care to this issue. And I think we can rally a lot of support.

REP. CONYERS: That's encouraging.

DR. RASELL: Well, this is a really important time for moving ahead on this issue. And Quentin has mentioned the amount of money that we spend on health care. And one of the side effects of the system that we have is all these -- as you mentioned, these interlocking, you know, diverse, overlapping, you know, different HMOs, Medicaid, Medicare -- you know, all these different systems -- is that it's very expensive to administer.

And so if we were to simplify and go to one system -- maybe something like Medicare, where everybody's got their card, they have insurance, they get to go to whatever doctor they want to, something like that, which actually is very cost-effective -- we'd save a lot of money in that.

REP. CONYERS: Don't most other industrial nations do it already?

DR. RASELL: That's exactly right. Much simplified systems.

So if we save money there, and we're talking maybe something like $100 billion saved in administrative savings --

REP. CONYERS: So we could do the right thing and save money? That happens very rarely in the Congress.

DR. YOUNG: That's right.

DR. RASELL: Right, yeah.

REP. CONYERS: As my colleague knows.

REP. CHRISTENSEN: And the Kaiser Foundation just had a -- yes, we usually don't follow the logical path.

REP. CONYERS: Yes.

REP. CHRISTENSEN: But the Kaiser Foundation recently did a study, and it showed very clearly that when you're not insured, you don't go for health care. So by the time you get to a doctor, you're so ill

that the cost of making you better is so much more --

REP. CONYERS: Yes.

REP. CHRISTENSEN: -- than if you had insurance that allow you to go and do the preventative care or the health maintenance, the health care costs would go down.

REP. CONYERS: Congresswoman, you just raised one incident that happened to me recently. In my neighborhood, wonderful family. I'm talking with the husband, and he was talking -- he was complaining about some illness that had gotten so bad that he had gone to emergency. And then -- and he said that they've got all -- I said, "Well, you went back to a doctor? Are you" --

He said, "No, I didn't, because I got it taken care of in Emergency."

And I said, "But this was life-threatening."

My point was --

REP. CHRISTENSEN: I've seen too

many people die.

REP. CONYERS: I couldn't even bring myself to try to give any friendly advice, because I didn't believe -- it was my belief that only people unemployed, in a semi-vagrant stage, stayed away from hospitals, and then they finally cut into the emergency room and get some pills or a bandage.

Here was a wonderful family, a middle-class family, two cars, wonderful home. And he said just as matter-of-factly, "I stay out of the hospitals; I never go to doctors unless I just have to go."

And I said, "Well, you know, prevention is one of the ways that we keep people going." And whenever someone says something like that, I think of this shock that I had of people who make it their business not to go. I thought this period in time had long gone by --

REP. CHRISTENSEN: No. No.

REP. CONYERS: -- that people were knocking on the doors and seeing doctors too much. And there are people that make it a point -- which is a very dangerous practice -- to wait until you have to go to Emergency and don't follow up.

DR. YOUNG: That's right. And Edie's point about capturing these hundreds of billions of dollars that are there as soon as we eliminate the administrative waste and waste of marketing, let me mentioned three or four big ones that we are neglecting.

Long-term care. We have an aging population. Chronic illness is more --

REP. CONYERS: And more of them coming into the aging population.

DR. YOUNG: If we don't plan for that, we're going to have the ultimate catastrophe of all our grandparents, and even our parents, living without any reasonable support.

We have to address that. The money

is there if we don't waste it in the ways we've been discussing.

Mental health. It never was great. But it's really bad now. These insurance companies restrict mental health services to so many visits a year. Well, anybody who's seeing somebody who's sick with serious mental disease, you can't say, "Six visits." And then what, suicide? Come on.

You mentioned prevention. We should tarry there. That's so important, the early detection of disease. And we have good tools. Not to use them fully is the ultimate human and fiscal folly. It's just dumb.

So it's all there. We look to the Congress to solve this problem.

REP. CONYERS: Well, what about the motivation part, Quentin? How do we build, and continue to build, a climate and an organization -- you know, citizens are inclined to be disorganized. They're asked to join in to help improve their local

schools. They're asked to join in to fight hunger, charities, church activities. But then after a while, you know, you kind of get played out, even the best of us. And I keep thinking that we've got to maybe look at how we organize in terms of pulling this struggle together again.

DR. YOUNG: Well, certainly. Let me first embellish the very important point that Dr. Christensen made about the NMA with its historic commitment to care of the people.

And the good news is there are other medical groups: American Medical Women's Association, which has a wonderful record on this; American Medical Student Association, I love that --

REP. CONYERS: They're great.

DR. YOUNG: Because they're the doctors of the future. And there are others. So you asked about the doctors. I gave you a partial answer in terms of the depression.

The other part is, they're waking up. But you asked a larger question, the biggest one that any democracy faced: How do you go from a problem to a solution? The ones that stick in my mind and probably yours is the way we did make breakthroughs on legalized segregation in the '50s and '60s. And it took organization. It took protest. It took crying out.

I think if I were thinking politically of where we are in the health system, we're in the disconsolate mood. We're in people's anger and rage rising. There's no unity, I have to confess, on the answer, because there's a lot of obscurity out there.

REP. CONYERS: Yes.

DR. YOUNG: The media do not do a good job. And the powerful interests that we've been talking about make sure that the public is confused as they seek to have solutions.

But half the battle is when people get thoroughly disgusted, and then the next move in a democracy is to make sure that there is remedy. So that sounds a little bit pontifical; I apologize. But I really believe that. I think we're very close to that ----- point, because the accumulated hurt of the system is substantial. When a person loses a grandparent when they shouldn't have, they never forget. It isn't that -- you know, a speeding ticket, you forget it after a while. It's cumulative.

And I think we're accumulating hurts in this system.

REP. CHRISTENSEN: That's right.

DR. RASELL: And if we do head into a recession -- and nobody can tell the future, but it seems that we may be headed in that direction, where unemployment rises, so people lose coverage that they got through their employers, and maybe some employers who are kind of squeezed financially drop

employee health insurance -- that maybe this number of people who are uninsured and underinsured really starts to go up. And it may be that it's going to take, unfortunately, something like that to really get people out in the streets, which is probably what it's going to take before we get any change.

REP. CONYERS: Well, this is a call to action. And civil rights and the protests and the successes that have come out of that struggle, not that it's ended, is a very good page of our not-too-distant past to revisit.

REP. CHRISTENSEN: And this is the new civil rights battlefield, as far as we can see. And we'll --

DR. YOUNG: And human rights.

REP. CHRISTENSEN: Yes. And we'll -- as we plan for the health brain trust with this Congress, our mantra's going to be, "We're sick and tired of being sick and tired." And people can really identify

with that.

REP. CONYERS: Fanny Lou Hamer (phonetic).

REP. CHRISTENSEN: We are sick and tired of being sick and tired. We're going to use that. And I think people -- especially people of color, people who've been disenfranchised, people in the rural areas -- are going to be able to identify with that.

REP. CONYERS: Thank you, Dr./Congresswoman Christensen, Dr. Rasell, and Dr. Quentin Young. What a pleasure to have all of you here.

REP. CHRISTENSEN: Thank you.

REP. CONYERS: Thanks so much.

DR. YOUNG: It was great to talk with you.

DR. RASELL: Thank you.

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